

THE BOARD OF MEDICAL EXAMINERS  
OF THE STATE OF NEVADA

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In the Matter of Charges and  
Complaint Against  
JUDD ANDERS, M.D.,  
Respondent.

Case No. 19-32760-1

FILED

JUL 18 2019

NEVADA STATE BOARD OF  
MEDICAL EXAMINERS

By: 

COMPLAINT

The Investigative Committee<sup>1</sup> (IC) of the Nevada State Board of Medical Examiners (Board), by and through Robert Kilroy, Esq. General Counsel and attorney for the IC, having a reasonable basis to believe that Judd Anders, .D. (Respondent), violated the provisions of Nevada Revised Statutes (NRS) Chapter 630 and the Nevada Administrative Code (NAC) Chapter 630 (collectively, the Medical Practice Act), hereby issues its Complaint, stating the IC's charges and allegations as follows:

1. Respondent was at all times relative to this Complaint a medical doctor holding an active license to practice medicine in the State of Nevada (License No. 13557). Respondent was originally licensed by the Board on July 1, 2010, and is currently licensed in active status.

2. Patient A's true identity is not disclosed herein to protect her privacy, but is disclosed in the Patient Designation served upon Respondent along with a copy of this Complaint.

3. On August 19, 2014, Patient A, a 24-year-old female and a registered nurse with a long history of anorexia, was extremely dehydrated, malnourished, and very weak when she was transported to the emergency room at St. Mary's Regional Medical Center (St. Mary's), and she remained at this location from August 19, 2014 through August 22, 2014. Patient A's initial evaluation indicated the following: BP 93/74, P 55, Temp. 97.7, WBC 3.7, HGB 15.0, Hct, 43.8,

<sup>1</sup> The Investigative Committee of the Nevada State Board of Medical Examiners, at the time this formal Complaint was authorized for filing, was composed of Board members Rachakonda D. Prabhu, M.D., Chairman, Ms. Sandy Peltyn and Victor M. Muro, M.D.

1 BUN 60, and a Creat of 0.52. Additionally, Patient A initial EKG showed atrial fibrillation,  
2 prolonged QT INT interval, and there was bradycardia noted so she was transferred to ICU for  
3 closer monitoring and a cardiologist was consulted. Patient A came under the care of Respondent  
4 and fellow hospitalist Dr. Deftu, M.D. It was planned for Patient A to be transferred to the  
5 Denver Health Medical Center<sup>2</sup>.

6 4. On August 21, 2014, Respondent, who was working the night shifts at St. Mary's,  
7 was informed, at approximately 4:50 a.m., by the nursing staff of Patient A's lab results, the CMP,  
8 magnesium, phosphate and ferritin results, and the serial BMPs. Additionally, the nursing staff  
9 indicated to Respondent that Patient A was not showing signs/symptoms of bleeding and her  
10 hemoglobin/hematocrit were stable. Respondent did not provide any further orders for cultures  
11 and empiric antibodies and/or a chest X-ray, but did inform staff that Dr. Deftu would be in that  
12 morning to see the patient. At 10:15 p.m., the nursing staff informed Respondent of Patient A's  
13 WBC of 1300 and a Plct of 22 from the 10:00 p.m. lab results of BMP, magnesium and phosphate,  
14 and cortisol levels. Respondent did not provide any further orders for cultures and empiric  
15 antibodies and/or a chest X-ray after being informed of Patient A's worsening condition.

16 5. On August 22, 2014, Patient A suffered from severe bradycardia with a WBC of  
17 1300, and was in shock with a BP of 78. Patient A was transferred to the ICU prior to her being  
18 placed upon an air ambulance to the Denver Health Medical Center. Upon Patient A's arrival, the  
19 records indicate that Patient A had blood cultures taken, and that she had pseudomonas aeruginosa  
20 and staphylococcus aureus in her blood. Later that day, Patient A expired, and her final summary  
21 states the cause of death as sepsis with shock and severe community acquired pneumonia.  
22 Records from the Denver Health Medical Center confirm that the staph (infection) was sensitive  
23 to the maxochllin and bacterium.

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28 <sup>2</sup> In 2013, Patient A previously underwent 6 months of treatment for her severe weight loss, very low BMI and other medical conditions, and was discharged without completing the entire treatment plan.

**Count I**

**NRS 630.301(4)**

**(Malpractice)**

6. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

7. NRS 630.301(4) provides that malpractice of a physician is grounds for initiating disciplinary action against a licensee.

8. NAC 630.040 defines malpractice as the failure of a physician, in treating a patient, to use the reasonable care, skill, or knowledge ordinarily used under similar circumstances.

9. As demonstrated by, but not limited to, the above-outlined facts, Respondent failed to use the reasonable care, skill or knowledge ordinarily used under similar circumstances when he rendered medical care and treatment to Patient A.

10. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

**Count II**

**NRS 630.3062(1)(a)**

**(Failure to Maintain Complete Medical Records)**

11. All of the allegations contained in the above paragraphs are hereby incorporated by reference as though fully set forth herein.

12. NRS 630.3062(1)(a) provides that the failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient is grounds for initiating discipline against a licensee.

13. Respondent failed to maintain complete medical records relating to the diagnosis, treatment and care of Patient A, by failing to document his actions when he treated Patient A, whose medical records were not timely, legible, accurate, and complete.

14. By reason of the foregoing, Respondent is subject to discipline by the Board as provided in NRS 630.352.

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1           **WHEREFORE**, the IC prays:

2           1.       That the Board give Respondent notice of the charges herein against him and give  
3 him notice that he may file an answer to the Complaint herein as set forth in NRS 630.339(2)  
4 within twenty (20) days of service of the Complaint;

5           2.       That the Board set a time and place for a formal hearing after holding an Early  
6 Case Conference pursuant to NRS 630.339(3);


7           3.       That the Board determine what sanctions to impose if it finds and concludes that  
8 there has been a violation or violations of the Medical Practice Act committed by Respondent;

9           4.       That the Board make, issue and serve on Respondent its findings of fact,  
10 conclusions of law and order, in writing, to include sanctions to be imposed; and

11          5.       That the Board take such other and further action as may be just and proper in these  
12 premises.

13           DATED this 15 day of July, 2019.

14                                   INVESTIGATIVE COMMITTEE OF THE  
15                                   NEVADA STATE BOARD OF MEDICAL EXAMINERS

16                                   By:   
17                                   Robert Kilroy, Esq., General Counsel  
18                                   Attorney for the Investigative Committee  
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VERIFICATION

STATE OF NEVADA            )  
  : ss.  
COUNTY OF CLARK         )

Rachakonda D. Prabhu, M.D., hereby deposes and states under penalty of perjury under the laws of the state of Nevada that he is the Chairman of the Investigative Committee of the Nevada State Board of Medical Examiners that authorized the foregoing Complaint against the Respondent herein; that he has read the foregoing Complaint; and that based upon information discovered during the course of the investigation into a complaint against Respondent, he believes the allegations and charges in the foregoing Complaint against Respondent are true, accurate and correct.

Dated this 17<sup>th</sup> day of July, 2019.

INVESTIGATIVE COMMITTEE OF THE NEVADA  
STATE BOARD OF MEDICAL EXAMINERS




Rachakonda D. Prabhu, M.D., Chairman

**CERTIFICATE OF MAILING**

I hereby certify that I am employed by Nevada State Board of Medical Examiners and that on the 17<sup>th</sup> day of July, 2019, I served a filed copy of the formal COMPLAINT, via USPS e-certified, return receipt mail to the following:

**Judd Anders, M.D., M.D.  
235 W. 6<sup>th</sup> Street  
Reno, NV 89503**

Dated this 18<sup>th</sup> day of July, 2019.

  
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Sheri L. Quigley, Legal Assistant